		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032938

Facility Name: THE ARC OF JACKSONVILLE, LTD.

Address: 1316 TENDICK (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: (217) 243-2405 **Fax #** (217) 245-1449

IDPA ID Number: 37-1120847001

Date of Initial License for Current Owners: 11/06/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MELVIN SIEGEL
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	93	Intermediate (ICF)	93	33,945	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	24,294	1,001		25,295	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,294	1,001		25,295	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.52%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/06/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/06/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # 8 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	80,831	5,371	4,870	91,072		91,072		91,072			1
2	Food Purchase		92,780		92,780		92,780	(532)	92,248			2
3	Housekeeping	57,564	9,596		67,160		67,160		67,160			3
4	Laundry	26,743	6,280		33,023		33,023		33,023			4
5	Heat and Other Utilities			49,370	49,370		49,370	1,701	51,071			5
6	Maintenance	21,952	22,428	14,734	59,114		59,114	(2,475)	56,639			6
7	Other (specify):*			5,629	5,629		5,629	89	5,718			7
8	**TOTAL General Services**	187,090	136,455	74,603	398,148		398,148	(1,217)	396,931			8
	B. Health Care and Programs											
9	Medical Director			9,500	9,500		9,500		9,500			9
10	Nursing and Medical Records	458,683	11,506	19,389	489,578		489,578	10,232	499,810			10
10a	Therapy											10a
11	Activities	28,992	5,486	3,393	37,871		37,871	(3,393)	34,478			11
12	Social Services	78,049	350		78,399		78,399		78,399			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	565,724	17,342	32,282	615,348		615,348	6,839	622,187			16
	C. General Administration											
17	Administrative	102,867		3,000	105,867		105,867	4,921	110,788			17
18	Directors Fees											18
19	Professional Services			136,166	136,166		136,166	(105,990)	30,176			19
20	Dues, Fees, Subscriptions & Promotions			10,100	10,100		10,100	(3,571)	6,529			20
21	Clerical & General Office Expenses	14,138	8,571	18,679	41,388		41,388	50,069	91,457			21
22	Employee Benefits & Payroll Taxes			121,772	121,772		121,772		121,772			22
23	Inservice Training & Education			1,770	1,770		1,770	313	2,083			23
24	Travel and Seminar			9,153	9,153		9,153	8,250	17,403			24
25	Other Admin. Staff Transportation			13,186	13,186		13,186	4,683	17,869			25
26	Insurance-Prop.Liab.Malpractice			12,000	12,000		12,000	567	12,567			26
27	Other (specify):*			5,304	5,304		5,304	7,227	12,531			27
28	**TOTAL General Administration**	117,005	8,571	331,130	456,706		456,706	(33,531)	423,175			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	869,819	162,368	438,015	1,470,202		1,470,202	(27,909)	1,442,293			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: THE ARC OF JACKSONVILLE, LTD. #0032938 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,870	
	REPAIRS & MAINTENANCE		0	
			0	4,870
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		9,773	
	ELECTRICITY		30,546	
	WATER		8,664	
	CABLE TV - LOBBY		387	
			0	49,370
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,768	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE CONSULTANT		11,633	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		1,333	
			0	
			0	
			0	14,734
7	**OTHER**			
	SCAVENGER		5,629	
	SECURITY SERVICE		0	5,629
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,500	9,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	8,398	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	943	
	PHARMACY CONSULTANT	XVIII B 39-2	840	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	9,208	
			0	
			0	19,389
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,393	
			0	3,393
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. **#0032938** **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	3,000	3,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,839	
	ADMINISTRATIVE CONSULTANTS	XIX C	29,725	
	PROFESSIONAL FEES	XIX C	19,489	
	BOOKKEEPING/ADMINIST. SERVICE		78,113	136,166
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,508	
	EMPLOYEE WANT ADS	XIX F	894	
	CONTRIBUTIONS	VI 20 XIX F	205	
	DUES & SUBSCRIPTIONS	XIX F	3,737	
	LICENSES & PERMITS	XIX F	1,117	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,295	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	344	10,100
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		569	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,342	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,553	
	MESSENGER SERVICE		1,215	
			0	18,679

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	66,375	
	UNEMPLOYMENT COMPENSATION	XIX D	20,301	
	WORKERS COMPENSATION INSURANCI	XIX D	18,676	
	HOSPITALIZATION INSURANCE	XIX D	15,688	
	EMPLOYEE BENEFITS - OTHER	XIX D	732	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	121,772
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,770	1,770
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	9,153	
			0	
			0	9,153
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		13,186	13,186
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		12,000	12,000
27	**OTHER**			
	BAD DEBTS	VI 24	5,304	
			0	5,304

GRAND TOTAL COLUMN 3 OTHER 438,015

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. #0032938 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			7,195	7,195		7,195	28,745	35,940			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,420	12,420		12,420	146,705	159,125			32
33	Real Estate Taxes			20,485	20,485		20,485		20,485			33
34	Rent-Facility & Grounds			146,657	146,657		146,657	(140,364)	6,293			34
35	Rent-Equipment & Vehicles			7,797	7,797		7,797	6,388	14,185			35
36	Other (specify):*											36
37	**TOTAL Ownership**			194,554	194,554		194,554	41,474	236,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,917	50,917		50,917		50,917			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			50,917	50,917		50,917		50,917			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	869,819	162,368	683,486	1,715,673		1,715,673	13,565	1,729,238			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,123	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(532)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,342)	21		18
19	Entertainment		20		19
20	Contributions	(1,500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,304)	27		24
25	Fund Raising, Advertising and Promotional	(2,508)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,063)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	23,628		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 23,628		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 13,565		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

THE ARC OF JACKSONVILLE, LTD.

ID#32938

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. #1 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(532)	0	0	0	0	0	0	0	0	0	0	(532)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,701	0	0	0	0	0	0	0	0	0	1,701	5
6	Maintenance	0	(2,475)	0	0	0	0	0	0	0	0	0	(2,475)	6
7	Other (specify):*	0	89	0	0	0	0	0	0	0	0	0	89	7
8	**TOTAL General Services**	(532)	(685)	0	0	0	0	0	0	0	0	0	(1,217)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	10,232	0	0	0	0	0	0	0	0	0	10,232	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,393)	0	0	0	0	0	0	0	0	0	(3,393)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	6,839	0	0	0	0	0	0	0	0	0	6,839	16
	C. General Administration													
17	Administrative	0	4,921	0	0	0	0	0	0	0	0	0	4,921	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(105,990)	0	0	0	0	0	0	0	0	0	(105,990)	19
20	Fees, Subscriptions & Promotions	(4,008)	437	0	0	0	0	0	0	0	0	0	(3,571)	20
21	Clerical & General Office Expenses	(1,342)	0	51,411	0	0	0	0	0	0	0	0	50,069	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	313	0	0	0	0	0	0	0	0	313	23
24	Travel and Seminar	0	0	8,250	0	0	0	0	0	0	0	0	8,250	24
25	Other Admin. Staff Transportation	0	0	4,683	0	0	0	0	0	0	0	0	4,683	25
26	Insurance-Prop.Liab.Malpractice	0	0	567	0	0	0	0	0	0	0	0	567	26
27	Other (specify):*	(5,304)	0	12,531	0	0	0	0	0	0	0	0	7,227	27
28	**TOTAL General Administration**	(10,654)	(100,632)	77,755	0	0	0	0	0	0	0	0	(33,531)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,186)	(94,478)	77,755	0	0	0	0	0	0	0	0	(27,909)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,123	0	408	27,214	0	0	0	0	0	0	0	28,745	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	107	146,598	0	0	0	0	0	0	0	146,705	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,293	(146,657)	0	0	0	0	0	0	0	(140,364)	34
35	Rent-Equipment & Vehicles	0	0	6,388	0	0	0	0	0	0	0	0	6,388	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,123	0	13,196	27,155	0	0	0	0	0	0	0	41,474	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,063)	(94,478)	90,951	27,155	0	0	0	0	0	0	0	13,565	45

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		LITCHFIELD TERRACE	LITCHFIELD	MAVIN	SKOKIE, IL	CONSULTING
		RIVER VIEW MANOR	LOVES PARK	ENTERPRISES, LTD.		BOOKKEEPING
SEE ATTACHED LIST		PARKVIEW TERRACE	EAST MOLINE			
		GOLDEN MOMENTS	JACKSONVILLE	IDEA ASSOCIATES	SKOKIE, IL	REAL ESTATE
		SPRINGFIELD TERRACE	SPRINGFIELD			
		VANDALIA TERRACE	VANDALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULTAN	$ 11,633			$	$ (11,633)	1
2	V	10	PSYCHO-SOCIAL CONSULTANT	3,448				(3,448)	2
3	V	11	ACTIVITIES CONSULTANT	3,393				(3,393)	3
4	V	19	ADMIN. /BKKP. FEES	78,113				(78,113)	4
5	V	19	ADMIN. /CONSULT. FEES	29,725				(29,725)	5
6	V	17	MGMT CONSULTANT	2,300				(2,300)	6
7	V	5	ELECTRICITY/GAS				1,701	1,701	7
8	V	6	MAINTENANCE & REPAIR				9,158	9,158	8
9	V	7	SCAVENGER				89	89	9
10	V	10	PSYCH-SOCIAL & NURSING				13,680	13,680	10
11	V	17	ADMINISTRATIVE SALARIES				7,221	7,221	11
12	V	19	PROFESSIONAL FEES				1,848	1,848	12
13	V	20	ADVERTISING				437	437	13
14	Total			$ 128,612			$ 34,134	$ * (94,478)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	$	MAVIN ENTERPRISES, LTD.		$ 51,411	$ 51,411	15
16	V	23	SEMINARS				313	313	16
17	V	24	TRAVEL				8,250	8,250	17
18	V	25	TRANSPORTATION				4,683	4,683	18
19	V	27	EMPLOYEE BENEFITS				12,531	12,531	19
20	V	30	DEPRECIATION (SL)				408	408	20
21	V	32	INTEREST				107	107	21
22	V	34	OFFICE RENT				6,293	6,293	22
23	V	35	EQUIPMENT RENT				6,388	6,388	23
24	V	26	INSURANCE				567	567	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 90,951	$ * 90,951	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 146,657	IDEA ASSOCIATES		$	$ (146,657)	15
16	V	30	DEPRECIATION				27,214	27,214	16
17	V	32	INTEREST				146,598	146,598	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 146,657			$ 173,812	$ * 27,155	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. #1938 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7					SEE ATTACHED SCHEDULE						7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAVIN ENTERPRISES, LTD.
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	141,473	7	$ 9,514	$	25,295	$ 1,701	1
2	6	MAINTENANCE & REPAIR	PATIENT DAYS	141,473	7	51,216	50,100	25,295	9,157	2
3	7	SCAVENGER	PATIENT DAYS	141,473	7	500		25,295	89	3
4	10	PSYCH-SOCIAL & NURSING	PATIENT DAYS	141,473	7	76,511		25,295	13,680	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	141,473	7	40,388	40,388	25,295	7,221	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	141,473	7	10,333		25,295	1,848	6
7	20	ADVERTISING	PATIENT DAYS	141,473	7	2,442		25,295	437	7
8	21	TOTAL OFFICE	PATIENT DAYS	141,473	7	287,536	218,675	25,295	51,411	8
9	23	SEMINARS	PATIENT DAYS	141,473	7	1,750		25,295	313	9
10	24	TRAVEL	PATIENT DAYS	141,473	7	46,140		25,295	8,250	10
11	25	TRANSPORTATION	PATIENT DAYS	141,473	7	26,191		25,295	4,683	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	141,473	7	70,083		25,295	12,531	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	141,473	7	2,285		25,295	409	13
14	32	INTEREST	PATIENT DAYS	141,473	7	601		25,295	107	14
15	34	OFFICE RENT	PATIENT DAYS	141,473	7	35,195		25,295	6,293	15
16	35	EQUIPMENT RENT	PATIENT DAYS	141,473	7	35,725		25,295	6,388	16
17	26	INSURANCE	PATIENT DAYS	141,473	7	3,172		25,295	567	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 699,582	$ 309,163		$ 125,085	25

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY						$	$			$	1
2	IDEA ASSOCIATES											2
3	BANK FINANCIAL		X	MORTGAGE	DEMAND	10/98	1,251,000	1,199,092			146,598	3
4												4
5	MGMT CO ALLOCATION										107	5
	Working Capital											
6	BANK FINANCIAL		X	LINE OF CREDIT	DEMAND	11/97					11,881	6
7	A. I. CREDIT CORPORATION		X	INSURANCE FINANSING							539	7
8												8
9	TOTAL Facility Related						$ 1,251,000	$ 1,199,092			$ 159,125	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,251,000	$ 1,199,092			$ 159,125	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 20,191	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 20,237	2
3. Under or (over) accrual (line 2 minus line 1).		$ 46	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 20,439	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 20,485	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	22,987	8
1999	23,304	9
2000	19,641	10
2001	20,191	11
2002	20,237	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE ARC OF JACKSONVILLE, LTD. COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0032938

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-29-103-018	NURSING HOME	$ 20,236.58	$ 20,236.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 20,236.58	$ 20,236.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1987	$ 15,700	1
2					2
3	TOTALS			$ 15,700	3

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1987		$ 857,227	$ 27,214	31.5	$ 27,214	$	$ 354,435	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1987	2,634	84	20	131	47	1,828	9
10	VARIOUS			1990	20,488	650	20	1,025	375	13,958	10
11	VARIOUS			1991	4,446	141	20	222	81	2,868	11
12	VARIOUS			1992	14,187	450	20	709	259	8,145	12
13	VARIOUS			1995	2,421	62	20	121	59	1,055	13
14	HEATER COVERS			1996	1,250	33	20	63	30	431	14
15	FLOOR TILE			1996	1,128	28	20	56	28	407	15
16	SMOKE DETECTORS			1996	929	23	20	46	23	366	16
17	TELEPHONE SYSTEM			1996	6,842	176	20	342	166	2,164	17
18	FLOOR TILE			1996	1,946	50	20	97	47	675	18
19	FLOOR TILE			1997	1,028	26	20	51	25	357	19
20	AIR HANDLERS & DUCTS			1997	3,725	95	20	186	91	1,253	20
21	CONDENSOR			1997	4,481	115	20	224	109	1,828	21
22	TILE			1997	3,410	88	20	170	82	1,097	22
23	DECORATING			1997	3,406	87	20	170	83	1,113	23
24	FENCE			1997	3,180	82	20	159	77	1,142	24
25	TILING			1997	2,740	70	20	137	67	845	25
26	SPRINKLER COMP			1997	825	21	20	41	20	249	26
27	CONCRETE SLAB APPROACH			1999	4,000	103	20	200	97	1,000	27
28	INSTALL RESIDENT CALL LIGHT SYSTEM			2000	16,698	607	27.5	607		2,123	28
29	ROOF REPAIR, INSTALLED DOWNSPOUT & GUTTER			2000	9,990	363	27.5	363		1,274	29
30	INSTALLED DOORS			2000	3,633	132	27.5	132		463	30
31	AIR CONDITIONERS			2000	1,477	55	27.5	55		190	31
32	BUMPER GUARDS, CAPS, HANDRAILS,BORDER TAGS			2000	10,952	398	27.5	398		1,396	32
33	REPAIR AUTOMATIC SPRINKLER SYSTEM			2000	3,422	124	27.5	124		431	33
34	TILE FOR B-HALL,COMPRESSOR FOR SPRINKLER SYSTEM			2001	1,621	59	27.5	59		148	34
35	FIRE ALARM EQUIPMENT FOR C-HALL			2001	3,168	115	27.5	115		288	35
36	INSTALLED TWO CAMERA'S, AIR CONDITIONERS			2001	2,244	82	27.5	82		205	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 993,498	$ 31,533		$ 33,299	$ 1,766	$ 401,734	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 46,402	$ 2,876	$ 2,233	$ (643)	8-10 YR	$ 31,895	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	MGMT CO ALLOCATION		408	408				74
75	TOTALS	$ 46,402	$ 3,284	$ 2,641	$ (643)		$ 31,895	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1986 FORD TRUCK	1996	$ 2,300	$	$	$		$ 2,300	76
77										77
78										78
79										79
80	TOTALS			$ 2,300	$	$	$		$ 2,300	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,057,900	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,817	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,940	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,123	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 435,929	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 4,805 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1997 FORD WAGON	$ 246.00	$ 2,992	17
18					18
19					19
20					20
21	TOTAL		$ 246.00	$ 2,992	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits			N/A				5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (45,168)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	197,392		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,428		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,389,593		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,609,245	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	139,249		15
16	Equipment, at Historical Cost	45,722		16
17	Accumulated Depreciation (book methods)	(71,703)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 113,268	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,722,513	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 337,869	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	83,933		28
29	Short-Term Notes Payable	631,187		29
30	Accrued Salaries Payable	35,235		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,573		31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,439		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,142,236	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,142,236	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 580,277	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,722,513	$	48

*(See instructions.)

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # 38 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 606,649	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	7,450	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 614,099	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(33,822)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (33,822)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 580,277	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,681,744	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,681,744	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	107	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 107	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,681,851	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	398,148	31
32	Health Care	615,348	32
33	General Administration	456,706	33
	B. Capital Expense		
34	Ownership	194,554	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	50,917	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,715,673	40
41	**Income before Income Taxes (line 30 minus line 40)****	(33,822)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (33,822)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,106	$ 46,330	$ 22.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	10,794	11,544	159,625	13.83	4
5	Nurse Aides & Orderlies	22,552	23,539	201,728	8.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,267	3,505	28,992	8.27	10
11	Social Service Workers	7,624	8,383	78,049	9.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,238	10,830	80,831	7.46	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,215	21,952	9.91	17
18	Housekeepers	7,264	7,783	57,564	7.40	18
19	Laundry	3,556	3,961	26,743	6.75	19
20	Administrator	1,879	2,079	53,688	25.82	20
21	Assistant Administrator	1,214	1,305	26,107	20.01	21
22	Other Administrative	773	800	23,072	28.84	22
23	Office Manager					23
24	Clerical	3,285	3,345	14,138	4.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	3,464	3,863	51,000	13.20	33
34	TOTAL (lines 1 - 33)	79,944	85,258	$ 869,819 *	$ 10.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 4,870	1-3	35
36	Medical Director	O	9,500	9-3	36
37	Medical Records Consultant	N	943	10-3	37
38	Nurse Consultant	T	9,208	10-3	38
39	Pharmacist Consultant	H	840	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,393	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL CONSULTANT		8,398	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 37,152		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. # Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BOBI SMITH	ADMIN	0	$ 53,688
CAIN SMITH	ASST ADMIN	0	26,107
	ADMIN CONSULT	0	23,072
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,867

B. Administrative - Other

Description	Amount
MELVIN SIEGEL	$ 3,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 3,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK,BOKOR,KAGDA	ACCOUNTING	$ 9,039
LEONARD WEISS	MGMT CONSULTANT	2,300
GARY A. WEINTRAUB	LEGAL FEES	6,200
LAW OFFICES OF J. BAKER	LEGAL FEES	188
PERSONNEL PLANNERS	U.C. CONSULTANT	1,762
NURSING CARE SYSTEMS	DATA PROCESSING	4,966
ALPHA DATA SERVICES	DATA PROCESSING	2,105
LTC SOLUTIONS, INC	DATA PROCESSING	1,320
BEST SOFTWARE OF CALIF.	DATA PROCESSING	448
MEVIN ENTERPRISES	BOOKKEEPING/ADMIN	78,113
MEVIN ENTERPRISES	ADMIN. CONSULTANT	29,725
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 136,166

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 18,676
Unemployment Compensation Insurance		20,301
FICA Taxes		66,375
Employee Health Insurance		15,688
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		732
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	894
Health Care Worker Background Check	344
(Indicate # of checks performed 25)	
MARKETING/ADV/PROMO	2,508
TRUST/FRANCHISE/CONTRIB/ETC	1,500
LICENSES & PERMITS	917
DUES & SUBSCRIPTIONS	3,737
MGMT CO ALLOCATION	437
TRUST/FRANCHISE/CONTRIB/ETC	(1,500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,508)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,529

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	9,153
MGMT CO ALLOCATION	8,250
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,403

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE ARC OF JACKSONVILLE, LTD. #938 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6								N/A					
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $3582**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **50,917**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees